

Patient Safety in the AMEDD



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Question

How old would you be
if you didn't know
how old you are?



Objectives

- Briefly Review Key Patient Safety Concepts and Program Definitions
- Discuss Components of the AMEDD Patient Safety (PS) Program
- Provide Overview of Joint Commission (JC) Patient Safety Standards and 2004 National Patient Safety Goals



Definitio n

Patient Safety

Actions undertaken by individuals and organizations to protect health care recipients from being harmed by the effects of health care services.



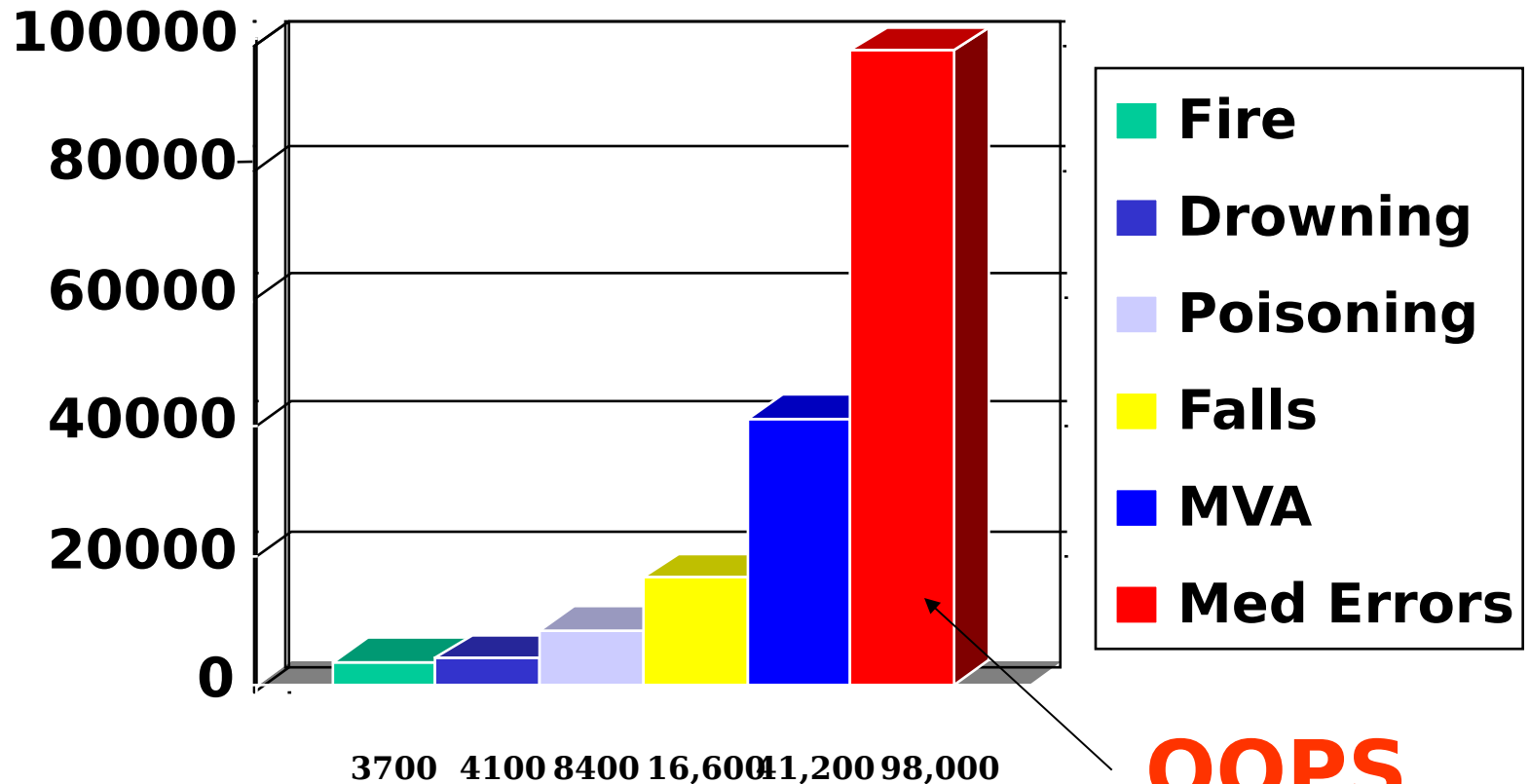
Why the Focus on Patient Safety?

- **Right Thing to Do!**
 - ✓ Saves lives, saves money
- **Response to the “Deadly Secret”**
 - ✓ IOM Report - To Err is Human
 - 44,000-98,000 deaths due to medical error
 - National Cost: \$17-29 Billion/year
 - 10-35% suffer from preventable adverse drug events cost hospitals \$2 Billion/year
- **Federal Mandate & Regulatory Requirement**
 - ✓ Presidential Directive, NDAA, DoDI, DoD IG
 - ✓ JCAHO requirements

Make the Safest Way the Best Way!



Deadly Secret



Make the Safest Way the Best Way!!



How to Lie with Statistics

“ Proper treatment will cure a cold in seven days, but left to itself a cold will hang on for a week.”

Henry G. Felsen



Program Goals

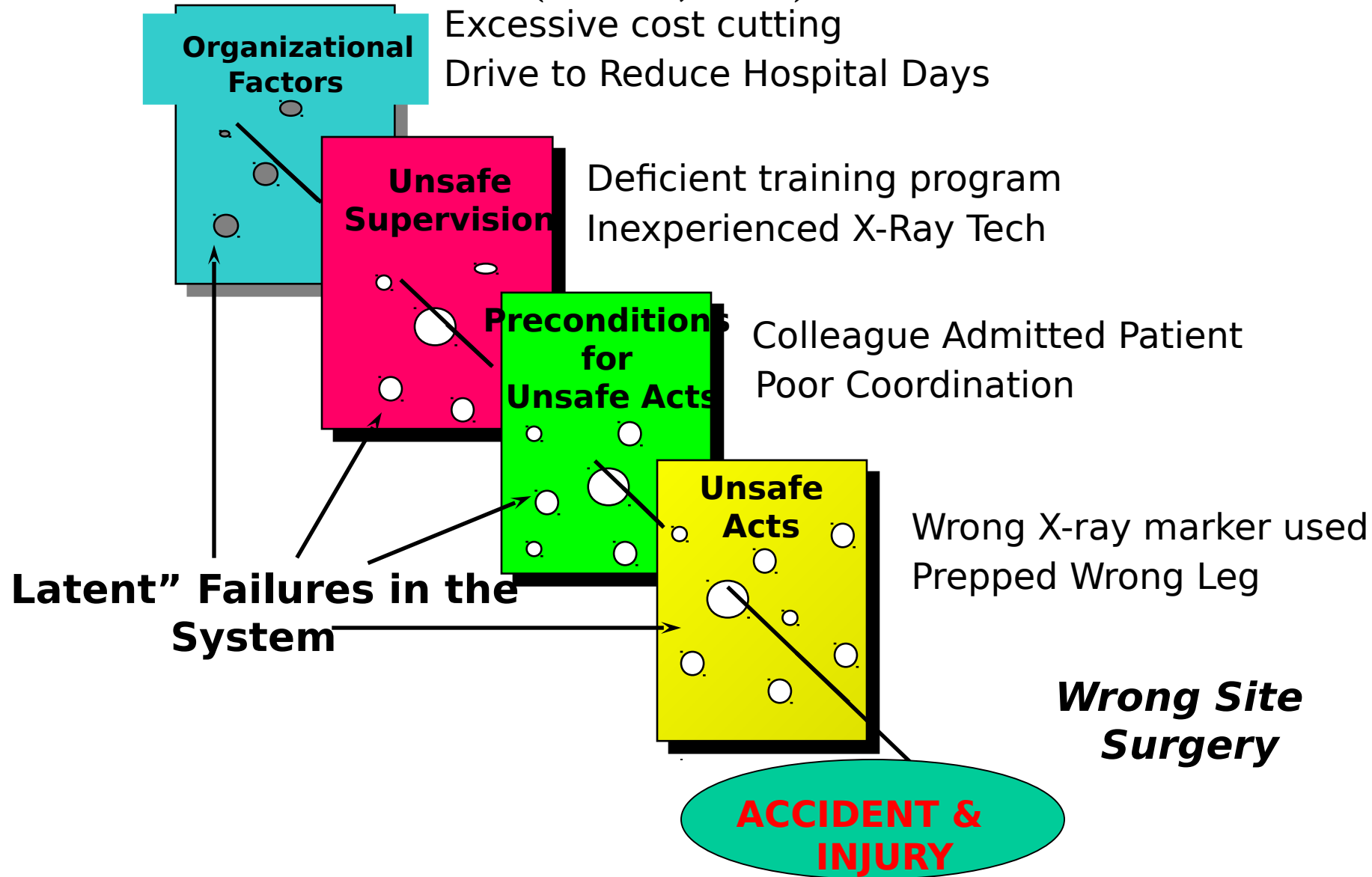
- Reduce chance of human error reaching & harming patients
- Promote culture to facilitate reporting
- Focus on system/process design **NOT** individual involved
- Ask What happened & Why **NOT** Who...

‘Paradigm Shift’ from current practice!

Make the Safest Way the Best Way!

The “Swiss Cheese” Model of Accident Causation

(Reason, 1990)





Current Reality

- **Error prevention is often hampered by:**
 - ✓ Lack of clear lines of authority, accountability and responsibility
 - ✓ Fragmented approaches spread out over multiple bodies, committees, departments and individuals
 - ✓ Incidence of errors are severely under-reported due to:
 - Fear of reprisal
 - Ineffective and limited reporting mechanisms
 - Insufficient aggregate data to analyze and make decisions



Culture & Reporting

- Cultural Change Needed
 - ✓ Encourage institutional learning from errors
 - ✓ Focus on systems and processes
 - ✓ Minimize individual blame
 - ✓ Promote voluntary reporting of errors



Safe System Design

Process Design

- Reduce reliance on memory and vigilance
- Simplify
- Decrease Variation
- Checklists
- Forcing functions
- Eliminate look & sound a-likes

Organizational Change

- Increase feedback
- Teamwork
- Drive out fear
- Leadership commitment
- Improve direct communication

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**“The hardest thing to
understand is Income Tax.”**

Albert Einstein

Readers Digest, Feb 2004, p. 222



Patient Safety & The Joint Commission



Patient Safety Program Survey Expectations

- **MTF-wide PS Program Implementation**
 - ✓ 1 year 'track record' - 1 July 02
- **"Annual" Requirements:**
 - ✓ Select high-risk process
 - ✓ Complete 1st Annual FMEA - 1 July 01- 1 Sep 02
 - ✓ Complete 2nd Annual FMEA - 1 Jul 02 - 1 Jul 03
 - ✓ Start on number 3 - 1 Jul 03 - 1 Jul 04
 - ✓ Implement PS Goals - 1 Jan 03

Survey Process Overview



➤ **Patient safety primary focus**

- ✓ Leadership interviews to evaluate if Patient Safety is an organizational priority
- ✓ Onsite survey agenda reflecting emphasis on Patient Safety
- ✓ Pt unit visits and staff interviews evaluate actual practice and performance
 - Tracer Methodology



Patient Safety & Health Literacy



Health Literacy

- **What is Health Literacy?**
- **Do we have a problem with Health Literacy?**
- **What can you do to help?**



Patient Safety & MEDCOM



AMEDD Leading the Way!

➤ **MEDCOM Regulation 40-41: The Patient Safety Program**

- ✓ Establishes “Standardized” Corporate Program (Currently under revision)
- ✓ Supports all Regulatory Requirements
 - Specific implementation guidance for
 - DoD Instruction 6025.17
 - NDAA 2001
 - JCAHO PS Standards



Definitions of Terms

➤ **Patient Safety (PS) Event**

- ✓ Incident that occurred (actual event) **or** almost occurred (close call/near miss) that caused or had the potential to cause harm to a patient

➤ **3 Types of PS Events**

- ✓ Close Call/Near Miss
- ✓ Adverse Event
- ✓ Sentinel Event



Near Miss*

Any process variation or error that could have resulted in harm to a patient, visitor or staff, but through chance or timely intervention did not reach the individual. Such events have also been referred to as 'close call(s)'

***Per DoD PS Planning & Coordination Committee (PSPCC) as of Jan 03**



Adverse Event

- **Occurrence associate w/ provision of health care or services that may or may not result in patient harm**
 - ✓ Acts of commission or omission
- ****Patient falls or improper medication administration, even if NO patient harm, fall into this PS event category**



Sentinel Event

**Unexpected occurrence
involving death, serious
physical or psychological
injury, “or risk thereof”**



JC Reviewable Sentinel Events

- **Applies to recipients of care**
 - **Applies only to events that meet the following criteria:**
 - ✓ Event resulted in unanticipated death or major permanent loss of function
 - ✓ Not related to the natural course of illness
- OR**



JC Reviewable Sentinel Events

- Suicide in a 24-hour Care Setting
- Infant Abduction/DC Wrong family
- Rape (by another pt, visitor, staff)
- Hemolytic Transfusion Reaction
- Surgery Wrong Patient/Body Part
- Unanticipated death of a full term infant



Other JC “Reviewable” Sentinel Events

- **Medication Error** resulting in Death, Paralysis, Coma or other Permanent Loss of Function
- **Maternal Death** (Intrapartum/Related to Birth Process)
- **Fall** resulting in Death or Permanent Loss of Function (Direct Result of Sustained Injuries)
- **Fatal Nosocomial Infection** considered SE and is reviewable
- **Surgical Fires** SE Alert #29



JC SE Statistics

(From Jan 95 - Jul 04)

current as of 31 July 2004

➤ **2768 Sentinel Events Reviewed by JC**

➤ **Categories of SE's to date include:**

401 Patient Suicide

346 Op/Post-Op Complications

346 Wrong Site Surgery event

317 Medication Error

199 Delay in Treatment

Death/Injury

128 Patient Fall

117 Restraint Death/Injury

98 Assault/Rape/Homicide

Abduction/wrong families

79 Transfusion Error

77 Perinatal Death/Loss Function

56 Patient Elopement

47 Fire

45 Anesthesia-related

42 Infection-Related Event

39 Ventilator

36 Med Equip Deaths

31 Maternal Death

21 Infant

18 Transfer-related event

325 Other less frequent

times

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28



Identified Root Cause/ Contributing Factors

JCAHO

1. Communication*
2. Orientation/Training*
3. Patient Assessment
4. Availability of Information
5. Staffing Levels*
6. Physical Environment
7. Competency/Credentialing
8. Procedural Complications
9. Alarm Systems

DoD

1. Communication*
2. No Policy/Procedure
3. Policy/Procedure not Followed
4. Inadequate Documentation
5. Lack of Training*
6. Staffing Levels*
7. Lack of Experience
8. Equipment Malfunction/
Availability



Communication

We know that
communication is a
problem, but we're not
going to discuss it with
the troops!



Systems Evaluation

(JC Minimum Scope of RCA)

- Patient Assessment
- Patient Identification
- Care Planning Process
- Availability of Information
- Orientation & Training
- Competence Assessment/
Credentialing
- Staff Supervision
- Staffing Levels
- Equipment Maintenance/
Management
- Technological Support
- Communication
 - ✓ Between Staff
 - ✓ Patient/Family
- Control of Medications
 - ✓ Storage/Access
 - ✓ Labeling
 - ✓ Security Systems/Processes



Reporting Medication Errors

What movie featured a scene depicting a Medication Error and the reporting of a Near Miss?



Root Cause Analysis (RCA)

A process for identifying the basic and causal factors that underlie variation in performance, to include the occurrence or possible occurrence of a sentinel event



Patient Safety &

JCAHO National Patient Safety Goals for 2004



JC National Patient Safety Goals

- Published 24 July 02
- Effective 1 July 03
 - ✓ 6 Goals
 - ✓ 1 Jan 03 MTFs must be in compliance
- Goal 7 published 18 July 03
- Effective 1 Jan 04
 - ✓ MTFs must be in compliance



GOAL 1

- **Improve Pt Identification Accuracy**
 - ✓ **Must use 2 patient identifiers whenever taking blood samples or administering medication or blood products**
 - ✓ **Surgical/Invasive Procedures – final verification process (time-out) using ‘active’ communication techniques (confirm correct patient & procedure)**



GOAL 2

➤ **Improve effectiveness of communication among caregivers**

- ✓ Implement process for taking verbal or telephone orders or critical test results requiring verification 'read-back' of complete order/result by person receiving order/result
- ✓ Standardize abbreviations, acronyms & symbols used throughout the organization & symbols not to use.



GOAL 3

➤ **Improve high-alert medications safety use**

- ✓ Remove concentrated electrolytes from patient care units
potassium chloride, phosphate & sodium chloride > 0.9%
- ✓ Standardize & limit number of drug concentrations available in the organization



GOAL 4

- **Eliminate wrong-site, wrong patient wrong surgery**
 - ✓ Create & use preoperative verification process (checklist) to confirm appropriate documents available
medical records, imaging studies, etc.
 - ✓ Implement process to mark surgical site & involve patient in process



GOAL 5

- **Improve safety of using infusion pumps**
 - ✓ Ensure free-flow protection on all general-use & PCA intravenous infusion pumps used in the organization



GOAL 6

- **Improve effectiveness of clinical alarm systems**
 - ✓ Implement regular prevention maintenance & testing of alarm systems
 - ✓ Assure alarms activated w/ appropriate settings & audible w/ respect to distance & competing noises w/in unit



GOAL 7

➤ **Reduce the risk of health care-acquired infections**

- ✓ Comply with current CDC Prevention (hand-hygiene) guidelines
- ✓ Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-acquired infection



NPSG Evaluation & Scoring

- Apply to ALL accreditation programs
 - ✓ Includes All Full Surveys & Unannounced Surveys
- Must implement all goals/recs relevant to scope of services, or implement JC approved alternative
- Surveyors evaluate actual performance, not just intent
 - ✓ Are recommendations implemented & how consistently are they being done
- Expected track record from 1 Jan 03 to survey date
- Failure to address 1 or more recommendation, will result in a Recommendation for Improvement or a Supplemental Recommendation for Improvement.



How Can You Assist?

**What I need is
an exact list of
specific unknown
problems we might
encounter.**



How Can You Assist?

- **Become educated on AMEDD PS Program & roles/responsibilities in daily practice**
- **Report all close calls, adverse events & sentinel events**
- **Ensure patient/family educated on how they can participate to facilitate safe care**
- **Remain informed of safety alerts & implement identified safe/best practices**
- **Integrate JC PS Goals into daily practice**



AMEDD - Leading the Way!

Our Key to Success is MTF Program 'Execution'

**We need each of YOU to
share your knowledge/expertise & become
active participants in clinical safety
to
transition to an environment of
Cooperation**

Make the Safest Way the Best Way!



Conclusion

Working together to

**Make the Safest Way the
Best Way!**

Thank You!



Remember

This project is so important, we can't let things that are more important interfere with it.